

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005051</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>INDIANA UNIVERSITY HEALTH</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1701 N SENATE BLVD INDIANAPOLIS, IN 46202</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This survey was for the investigation of one State hospital complaint.</p> <p>Complaint#: IN00178065 Unsubstantiated: Lack of sufficient evidence.</p> <p>Facility number: 005051</p> <p>Date: 9/14/15 to 09/16/2015</p> <p>Indiana University Health is in compliance with 410 IAC 15-1.5-6, Nursing Services, Hospital Licensure Rules.</p> <p>QA: JL 10/06/15</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE